Attachment B

South Carolina Department of Disabilities and Special Needs

RESIDENTIAL RESPITE

Consumer Name: _____ Consumer SSN: _____

DSN Board/Private Provider: _____

Proposed Respite Description

Residential Program In Which Respite Is To Be Provided: _____

Type of Residential Program (e.g., CTH I, CTH II, CRCF, ICF/MR): _____

Estimated Duration Of Respite (Dates): _____

Reason For Respite:

_____

_____

_____

Is there sufficient licensed bed capacity to accommodate respite? ____ Yes ____ No

Is consumer to receive respite compatible with other consumers residing in home? ____ Yes ____ No

Have other consumers agreed to respite? ____ Yes ____ No

Has other consumer agreed to use of bedroom (if applicable)? ____ Yes ____ No

Proposed Resolution (if "No" checked on either of three previous questions): _____

_____

_____

DSN Board/Private Provider Certification

I hereby certify that the information contained in this report is accurate.

_____ _____

Executive Director Signature Date

SCDDSN Approval

_____ _____

Assistant District Director Date

_____ _____

District Director Date

(submit to DDSN District Office Assistant District Director)

SAMPLE